

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-017909

STATE FILE NUMBER

1946

Health,
Welfare
Public
Service

00
57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
All diseases in Part I must be causally related.

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1946

1. PLACE OF DEATH
a. COUNTY Jackson

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City Inside Limits Yes No

c. CITY OR TOWN Kansas City 34 Inside Limits Yes No

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph Hosp 32 years 100^d STREET ADDRESS (If outside, give location) 4707 E. 112th Ter Reside on Farm Yes No

3. NAME OF DECEASED First Middle Last 4. DATE OF DEATH Month Day Year
Deloris Aline Popplewell 4 - 16 - 59

5. SEX Female 6. COLOR OR RACE White 7. MARRIED NEVER MARRIED WIDOWED DIVORCED 8. DATE OF BIRTH 11-6-34 9. AGE (In years last birthday) 24 10. FUNDER 1 YEAR Months Days 11. BIRTHPLACE (City and state or country) Colcord, Oklahoma 12. CITIZEN OF WHAT COUNTRY? U S A

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY At Home 13a. FATHER'S NAME Clarence Kirby 13b. MOTHER'S MAIDEN NAME Ethel Brazil 14. NAME OF HUSBAND OR WIFE Reagan Popplewell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) NO 16. SOCIAL SECURITY NO. — 17. INFORMANT Address Reagan Popplewell, 4707 E. 112th Terr.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatous INTERVAL BETWEEN ONSET AND DEATH one year
DUE TO (b) Malignant Melanoma one year
DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES NO 1909

20a. ACCIDENT SUICIDE HOMICIDE 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) _____
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. _____

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ 20f. CITY, TOWN, OR LOCATION COUNTY STATE _____

21. I attended the deceased from 4-16-59 and last saw her alive on 4-16-59
Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) J. P. McCalla M.D. 22b. ADDRESS 6312 Raytown Rd, Raytown, Mo. 22c. DATE SIGNED 4-17-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE 4-18-59 23c. NAME OF CEMETERY OR CREMATORY Mt. Moriah Cemetery 23d. LOCATION (City, town, or county) (State) Kansas City, Missouri

24. FUNERAL DIRECTOR ADDRESS E. K. George & Sons Inc, Grandview 25. DATE RECD. BY LOCAL REG. 4-18-59 26. REGISTRAR'S SIGNATURE Irlva Marshall

1121

Bo 1, 5482

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Herby E. Dodard*

Licensed Embalmer No. *4911*
P. O. Address *Grandview Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.